# 2010 Medical Benefits Highlights - Most City of Seattle Employees

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

| Group Health Cooperative (GHC) | | City of Seattle Traditional Plan | | City of Seattle Preventive Plan | |
|---|---|---|---|---|---|
| **Standard Plan** | **Deductible Plan** | **Aetna In-Network** | **Out-of-Network** | **Aetna In-Network** | **Out-of-Network** |
| **Deductible** (per calendar year) | | | | | |
| No Deductible | $200 per person<br>$600 per family<br>Deductible applies except for prescriptions, preventive visits, ambulance, and durable medical equipment, except as noted. | $400 per person<br>$1,200 per family<br>Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies. | $1,000 per person<br>$3,000 per family | $100 per person<br>$300 per family<br>Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies. | $450 per person<br>$1,350 per family |
| **Annual Out of Pocket Maximum (OOP Max)** Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max. | | | | | |
| $2,000 per person<br>$4,000 per family | $2,000 per person<br>$6,000 per family | $1,000 per person<br>$3,000 per family | $2,000 per person*<br>$6,000 per family* | $2,000 per person<br>$4,000 per family | $3,000 per person*<br>$6,000 per family* |
| **Maximum Lifetime Benefits Payable** | | | | | |
| Combined $2,000,000 lifetime maximum for Standard and Deductible plans | | Combined $2,000,000 lifetime maximum in- and out-of-network for Traditional and Preventive plans | | | |
| **Hospital Copay** | | | | | |
| $200 per admission | Deductible applies | $200 copay per admission | $200 copay per admission | $200 copay per admission | $200 copay per admission |
| **Hospital Pre-admission Authorization** | | | | | |
| Except for maternity or emergency admissions, must be authorized by GHC | | Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission | | Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission | |
| **Choice of Providers** | | | | | |
| All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists. | | Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit. | Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges. | Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit. | Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges. |
| **COVERED EXPENSES** | | | | | |
| **Acupuncture** | | | | | |
| $15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral. | $15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral. Deductible applies. | Paid at 80%<br>Maximum of 60 visits per calendar year in- and out-of-network combined. Provider must submit medical necessity statement at 20th visit. | Paid at 60% | Paid at 100% after $15 copay<br>Maximum of 60 visits per calendar year in- and out-of-network combined. Provider must submit medical necessity statement at 20th visit. | Paid at 60% |
| **Alcohol/Drug Abuse Treatment** | | | | | |
| Inpatient: Paid at 100% after $200 copay<br>Outpatient: Paid at 100% after $15 copay | Inpatient: Paid at 100% after deductible<br>Outpatient: Paid at 100% after $15 co-pay. Deductible applies. | Inpatient: Paid at 80% after $200 copay<br>Outpatient: Paid at 80% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% | Inpatient: Paid at 90% after $200 copay<br>Outpatient: Paid at 100% after $15 copay | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% |
| **Contraceptives** | | | | | |
| For contraceptive drugs and devices, see Prescription Drug benefit | | IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. | | IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. | |
| **Durable Medical Equipment** | | | | | |
| Paid at 80% | Paid at 80% | Paid at 80% | Paid at 60% | Paid at 90% | Paid at 60% |

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| **Emergency Medical Care** | | | | | |
| ➢ **Urgent Care Clinic** | | | | | |
| Paid at 100% after $15 copay | $15 copay for most visits. Deductible applies. | Paid at 80% | Paid at 60% | Paid at 100% after $15 copay (no fee for preventive care) | Paid at 60% |
| ➢ **Emergency Room (copays waived if admitted)** | | | | | |
| GHC facility: $100 copay<br>Non-GHC facility: $150 copay | GHC facility: $100 copay<br>Non-GHC facility: $150 copay<br>Deductible applies | Paid at 80% after $150 copay | Paid at 80% after $150 copay. If non-emergency, paid at 60% after copay. | Paid at 90% after $150 copay | Paid at 90% after $150 copay. If non-emergency, paid at 60% after copay. |
| ➢ **Ambulance** | | | | | |
| Paid at 80%.<br>GHC-initiated non-emergency transfers are paid at 100% | Paid at 80%.<br>GHC-initiated non-emergency transfers are paid at 100% | Paid at 80% when medically necessary. | | Paid at 90% when medically necessary.<br>Non-emergency transportation must be approved in advance by Aetna. | |
| **Hearing Aids (per ear, every 36 months)** | | | | | |
| Up to $1,000 | Up to $1,000 | Up to $1,000<br>In-network coinsurance applies whether purchased in or out-of-network. Deductible does not apply. | Up to $1,000 | Up to $1,000<br>In-network coinsurance applies whether purchased in or out-of-network. Deductible does not apply. | Up to $1,000 |
| **Home Health Care** | | | | | |
| Paid at 100% when authorized.<br>No visit limit. | Paid at 100% when authorized.<br>No visit limit. | Paid at 80%<br>Maximum benefit of 130 visits per calendar year for in- and out-of-network combined | Paid at 60% | Paid at 90%<br>Maximum benefit of 130 visits per calendar year for in- and out-of-network combined | Paid at 60% |
| **Hospital Inpatient** | | | | | |
| Paid at 100% after $200 copay per admission | Paid at 100% after deductible. | Paid at 80% after $200 copay. Physician services paid at 70% if Aexcel** specialist not used in specialty areas. | Paid at 60% after $200 copay | Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel** specialist not used in specialty areas. | Paid at 60% after $200 copay |
| **Hospital Outpatient** | | | | | |
| Paid at 100% after $15 copay | $15 copay. Deductible applies. | Paid at 80% after deductible. Physician services paid at 70% if Aexcel** specialist is not used in specialty areas. | Paid at 60% after satisfaction of deductible | Paid at 90% after deductible. Physician services paid at 80% if Aexcel** specialist is not used in specialty areas. | Paid at 60% after satisfaction of deductible |
| **Hospice** | | | | | |
| Paid at 100% when authorized | Paid at 100% when authorized | Paid at 80%<br>Lifetime maximum of 6 months or $10,000, whichever is greater. 14-day inpatient limit; 120-hour outpatient limit. | Paid at 60% | Paid at 90% | Not covered |
| **Maternity Care (**delivery & related hospital) | | | | | |
| Paid at 100% after $200 copay | Deductible applies. | Paid at 80% after $200 copay | Paid at 60% after $200 copay | Paid at 90% after $200 copay | Paid at 60% after $200 copay |
| **Maternity Care** (prenatal and postpartum) | | | | | |
| Paid at 100% after $15 copay | $15 copay. Deductible applies. | Paid at 80% | Paid at 60% | Paid 100% after one $15 copay | Paid at 60% |
| **Mental Health Care** (inpatient) | | | | | |
| Paid at 100% after $200 copay | Paid at 100% after deductible. | Paid at 80% after $200 copay | Paid at 60% after $200 copay | Paid at 90% after $200 copay | Paid at 60% after $200 copay |
| **Mental Health Care** (outpatient) | | | | | |
| Paid at 100% after $15 copay per individual, family or couple session. | $15 copay per individual, family or couple session. Deductible applies. | Paid at 80% after deductible.<br>Coinsurance does not apply to OOP Max. | | Paid at 100% after $15 copay | Paid at 60% after deductible. Coinsurance applies to OOP Max. |

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| **Physician Office Visit** | | | | | |
| Paid at 100% after $15 copay. | Paid at 100% after $15 copay for most visits. Deductible applies. | Paid at 80% | Paid at 60% | Paid at 100% after $15 copay per visit (waived for preventive care) | Paid at 60% |
| **Prescription Drugs** (retail) | | | | | |
| For a 30 day supply:<br>**Generic**: $15 copay<br>**Brand:** $30 copay<br>Contraceptive drugs and devices are covered subject to the pharmacy copay. | For a 30-day supply:<br>**Generic**: $15 copay<br>**Brand:** $30 copay<br>Contraceptive drugs and devices are covered subject to the pharmacy copay. | For a 31-day supply:<br>**Generic**: 30% coinsurance.<br>**Brand**: 40% coinsurance<br>The minimum coinsurance is $10, or actual cost of the drug if less.<br>Maximum is $100 per drug. | Not covered | For a 31-day supply:<br>**Generic**: 30% coinsurance<br>**Brand:** 40% coinsurance<br>The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug. | Not covered |
| Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay. | Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay. | Coinsurance applies to the prescription $1,200 out-of-pocket annual maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment). City pays $20 per month, and plan participant pays remaining; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy. | | | |
| **Prescription Drugs** (mail order) | | | | | |
| For a 90 day supply:<br>**Generic**: $45 copay<br>**Brand:** $90 copay<br><br>Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the OOP Max. | For a 90 day supply:<br>**Generic**: $30 copay<br>**Brand:** $60 copay | For a 90-day supply:<br>**Generic**: 30% coinsurance<br>**Brand**: 40% coinsurance<br>Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug. | Not Covered | For a 90-day supply:<br>**Generic**: 30% coinsurance<br>**Brand:** 40% coinsurance<br>Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug. | Not Covered |
| **Preventive Care** | | | | | |
| Paid at 100% after $15 copay<br>Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening. | Paid at 100% after $15 copay<br>Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening<br><br>Hearing exams subject to deductible. | Mammograms paid at 80%.<br><br>No other preventive services are covered | Mammograms paid at 60% | Paid at 100% (copay waived)<br>Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening. | Paid at 60% for well woman care and mammograms.<br><br>No other preventive services covered |
| **Rehabilitation Services** (inpatient) | | | | | |
| Paid at 100% after $200 copay per admission<br>Maximum of 60 days per calendar year (combined with other therapy benefits) | Paid at 100% after deductible. | Paid at 80% after $200 copay<br>Maximum of $50,000 per condition for in- and out-of-network combined | Paid at 60% after $200 copay | Paid at 90% after $200 copay<br>Maximum of 120 days per calendar year for in- and out-of-network combined | Paid at 60% after $200 copay |
| **Rehabilitation Services** (outpatient) | | | | | |
| Paid at 100% after $15 copay<br>Maximum of 60 visits per calendar year (combined with other therapy benefits) | $15 copay | Paid at 80%<br>Includes physical/massage, speech, and occupational therapy. Maximum of 60 visits combined per calendar year. Coinsurance does not apply to OOP Max. Provider must provide medical necessity statement at 20th visit. | Paid at 60% | Paid at 100% after $15 copay<br>Includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 60 visits combined per calendar year including in- and out-of-network. Provider must submit medical necessity statement at 20th visit. | Paid at 60% |

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| **Skilled Nursing Facility** | | | | | |
| Paid at 100%. 60 day maximum per calendar year. | 60 day maximum per calendar year. Paid at 100% after deductible. | Paid at 80% after $200 copay<br>Maximum of 90 days per calendar year for in- and out-of-network combined | Paid at 60% after $200 copay | Paid at 90% after $200 copay<br>Maximum of 120 days per calendar year for in- and out-of-network combined | Paid at 60% after $200 copay |
| **Smoking Cessation** | | | | | |
| Paid at 100% for individual or group sessions<br>Nicotine replacement therapy included in Prescription Drug benefit | Paid at 100% for individual or group sessions | Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand drugs. See Prescription Drugs, retail. | Not covered | Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance. | Not covered |
| **Spinal Manipulations** | | | | | |
| Paid at 100% after $15 copay<br>Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year. | $15 copay. Deductible applies. | Paid at 80%<br>Maximum of 10 visits per calendar year for in-network and out-of-network combined. | Paid at 60% | Paid at 100% after $15 copay<br>Maximum of 20 visits per calendar year for in-network and out-of-network combined. | Paid at 60% |
| **Sterilization Procedures** | | | | | |
| Outpatient: Paid at 100% after $15 copay | Outpatient: $15 copay. Deductible applies. | Inpatient: Paid at 80% after $200 copay<br>Outpatient: Paid at 80% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% | Inpatient: Paid at 90% after $200 copay<br>Outpatient: Paid at 90% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% |
| **Tooth Injury** (due to accident) | | | | | |
| Not covered | Not covered | Inpatient: Paid at 80% after $200 copay<br>Outpatient: Paid at 80% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% | Inpatient: Paid at 90% after $200 copay<br>Outpatient: Paid at 100% after $15 copay for office visit. Other charges paid at 90% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% |
| **Vision Hardware** | | | | | |
| Exam: Paid at 100% after $15 copay at GHC.<br>Hardware: Not covered. | Exam: Paid at 100% after $15 copay at GHC.<br>Hardware: Not covered. | Covered under Vision Service Plan. | | Covered under Vision Service Plan. | |
| **X-ray and Lab Tests** | | | | | |
| Paid at 100% | Paid at 100%. Deductible applies. | Paid at 80% | Paid at 60% | Paid at 90% | Paid at 60% |

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

** Applies to Aetna – Aexcel network, a specialty network of doctors in 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum).

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